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REQUEST FOR APPLICATION
A CONSUMER-CENTRIC HEALTH INFORMATION EXCHANGE FOR MARYLAND
ADDENDUM

For your reference, below are questions/clarifications received on this procurement.

1. Can additional details be provided regarding the funding mechanism and disbursement? What legal entity will hold the contract with the winning applicant?

Funding of the RFA is through the HSCRC all-payer rate setting system. The HSCRC will issue a rate order letter to participating hospitals, not a contract. It will be up to the hospital to identify the multi-stakeholder group participants to disburse the funds. That is the funds will go to the hospital and the hospitals will then, either a hospital or multiple hospitals will distribute the funds accordingly. Ongoing adjustments in rates are contingent on performance identified in the RFA and in the rate order letter.

(Dr. Cowdry commented, "That's sort of a unique feature of Maryland as you know, only state in the nation with an all-payer system, and it allows us to do some things by involving all payers in funding things for the common good, like the exchange. So that's the mechanism. Obviously since it's a hospital rate paying system the money flows through the hospitals.")

2. Is it just the hospitals or is it nursing homes too?

The funding actually flows to the hospitals. If the multi-stakeholders consist of long-term care facilities and other organizations, it will be the responsibility of that hospital and the group to decide how funding is going to be split between the participants. Therefore, the hospital is a funding intermediary for the entity.

3. Please, clarify the RFA requirements for the multi-stakeholder group's role in resolving many modeling and governance matters. Please describe how the responsibilities of the policy board and governance will complement one another.

- The Exchange proper will be incorporated as a 501(c)(3) non-profit and will be governed by the Board proposed in the response to the RFA. This governance will be responsible for the planning and operation of the exchange.
- The importance of a multi-stakeholder group cannot be overestimated. If a state-wide exchange is to succeed, it must be broadly representative and widely trusted. The breadth of participation in the group receives a greater weight than any other evaluation factor.
- The Policy Board will be established by the Commissions. By its very nature, the Exchange itself will predominantly involve providers. The Policy Board, in contrast, will predominantly involve non-providers and will focus on broad policy issues, particularly those related to privacy and security provisions essential to building public trust, not specific solutions. The intent is not to micromanage but rather to set policy parameters within which the exchange operates. For example, policy regarding authorizations required for different types of access to health information and policy regarding the number and type of factors required for authentication in different circumstances are issues that the Policy Board set
- The Governance of the Exchange and the Policy Board have some limited joint membership and will be expected to collaborate in crafting policies that are appropriate, technically feasible, and acceptable to both the public and providers.

4. Can you state which group is going to be the 501(c)(3)?

The exchange. They have two years to establish a 501(c)(3). We assume that it would be nice if that proceeded rapidly after designation, I think it's probably better for everybody involved, but we assume that that would be the ultimate corporate structure.

5. As a follow-up, back to question one, so there won't be a contract per se, there will be a rate letter?

This is very important. This is not a contractual process. We've borrowed many things from contracting because we think that's a good way to go about this but it is not a contract. It is an agreement between the HSCRC and hospitals to provide funding through the rate adjustment, and the hospitals then are responsible for channeling those funds to the 501(c)(3) or however it's structured, that's what would happen.

6. And then the 501(c)(3) would channel that money to the vendor community to the extent that we would be part of that group.

Yes.

7. Is it the MHCC's intent for respondents to choose a technology solution prior to response to be able to provide the details requested, or can we respond with less detail in order to keep multiple vendor solutions open?

RFA responders could specify the vendor solution or the process by which a solution will be chosen. If the responder decides to specify the process by which the solution will be chosen, the responder should expect a provision in the rate order letter regarding approval of the technical solution by the commissions since we were not able to review the solution as part of the RFA response.

8. Is it open for any type of operating system, architecture database development or anything like that?

We have set this up to be vendor neutral. We did not go in with an architecture or a vendor in mind. We're leaving that up to the exchange.

9. No content on any technology or anything like that, it's open?

That is correct.

10. Would a multi-stakeholder group be disadvantaged by coming into the process without having identified a vendor solution as part of the response?

No, they would not be disadvantaged by not including that. We simply are saying that there would be a process on that side of the commission to approve that technology.

(Dr. Cowdry commented, "The RFA does not envision a single state database with everybody, it's all information. We don't envision a centralized database solution to the problems of health information exchange in the state. Clearly what's described in here is much more a federated model with individual providers publishing information and then constraints being placed on how that information is retrieved from DH servers or whatever the technical option. So to that extent I think there's a bias in the RFA not to have a single central database where all of our, us that are in Maryland, health records are stored, so in that sense there's a bit of solution.")

12. Are there standards like NIH standards that you are going to be following that we should be aware of?

The industry accepted standards are those that we would be looking for in the application. We have not intended that it must be an ebXML product or vendor solution.

13. Can a solution be crafted from the ground floor up or must one be somewhat already pre-established to exist in the marketplace?

We are not saying that there can't be entrepreneurship, but what we're looking for is that these products meet standards. For example, you were talking about an EMR/EHR, that it already meets the certification, it has the CDHIT certification status, at this point in time, but we didn't limit the product listing to a certain group, we just said that it had to have standard base and have certification.

14. Will providers be allowed to augment the consumer's HIE data or would they be limited to strictly read-only access?

The HIE fundamentally exchanges provider data. As health record banks and PHRs develop, consumers could conceivably control user rights to that information. So essentially, it's very limited today. The question about read-only access was not something we conceived of for the large data that flows through the exchange.

15. Does the solution need to provide a process to disable access to data initially granted for use in analytical reporting purposes? Then secondly, do tiered access rights need to be supported in which specific components of the database are available, based on the individual's role?

Authorization that was in place at the time that the data were exchanged or transmitted are the authorizations that govern the data and that there's no need, should a person subsequently change their mind, to claw back the information that was validly exchanged at the time it was initially exchanged.

16. How do you terminate those rights if a child passes from one parent to another parent or from an elderly parent?

You change the consent, and that's effective going forward. There needs to be a way for consumers or whoever is authorized by law to change consents that are in the system, including the ability to opt out entirely from the exchange, which we hope will be seldom exercised.

17. Please, clarify what is meant by early functionality?

The phrase early functionality is used in the introduction of the RFA where it states this RFA seeks proposals to develop the infrastructure and early functionality of a statewide HIE. Responders should refer back to the Exchange Functionality on pages 17 and 18 of the RFA where the criteria for selecting the uses cases is discussed in detail.

18. In another point in the RFA it mentioned trying to have both phase one and phase two organizations live within five years. Was there anything about an expectation about when the phase one organizations would be live or anything other than those five years?

The RFA specifies the timeframe but it doesn't identify a hierarchy for that implementation. We would be leaving it to the responders to detail that for us.

19. Different entities being brought up like the human services and other things, do you foresee like insurance carriers like CareFirst or medicine providers like Merck or anybody using this information exchange to get the statistical data that they follow to process a claim is in the same information exchange, do you see that as part of this?

We think that there are ways that the exchange could provide information that would actually facilitate claims processing, but this is going to be one of the issues and we would actually hope that carriers are represented as well in this. We would certainly include a carrier representative on the policy board to discuss how this can be done in a way that providers are comfortable with, carriers find useful and that makes claims adjudication more efficient than it is today. However, I think it's going to be a little while down the road before these data will be really useful in terms of the adjudication process.

20. Could the commissions provide estimates of annual volumes of information-request transactions subject to the HIE? For example, how many requests for information do various health care providers

and family physicians make? What sources of such information is recommended for responders to prepare revenue projections and estimate operating costs for the anticipated volume of activity?

It would not be possible for us to provide estimates on annual volume at this time. Determining estimates depends on the schedule of implementation of the uses cases. Ideally, because of the likely utility of the information, the exchange would make available a CCR like document for all transfers between providers and most, and for most clinical encounters. Therefore, with reference simply to volume, at this point it's not an easy predictor. We would not be able to gauge what those transaction volumes would look like, how many and any sort of timing for them.

21. What are the performance metrics, such as system availability and system response time for key application functions?

We expect this will be part of the vendor selection criteria used by the exchange, to identify either the vendor or the performance of technology. The larger problem will be posing a solution to ensure availability of data from non-24/7 providers.

22. Have minimum return on investment or net present value targets been established that the responder must meet?

We assume these calculations will be part of the financial feasibility model for achieving sustainability based on the initial investment of the state. So here again, we would turn to the multi-stakeholder group to provide us with their recommendations as it relates to our line and to net present value.

23. Would you elaborate on the application evaluation process?

The basic evaluation will be conducted by the staff of the commission, who will evaluate the applications they receive, will draw as necessary on additional expertise from individuals who are unconnected with any of the applicant multi-stakeholder groups. At least three raters, who may be staff, who may also draw on outside experts, will independently score the applications and then meet to resolve and discuss differences and recommendations. If any of these applications are found to be satisfactory, perhaps even stellar, the staff will meet with those applicant groups to resolve any issues that were not addressed in the initial applications and to identify best and final proposals. One or more of these will be recommended to the members of the Maryland Health Care Commission for action. Many of you will recall that the commission proposes and the Health Services Cost Review Commission disposes. Therefore, that recommendation then goes over to the HSCRC for action to award the rate adjustment and they will issue the rate adjustment letter.

24. Is it possible that more than one award would be made?

I think our anticipation always has been that there will be a single awardee to develop the information exchange with the state.

25. We understand that the IT solution is one of the things; there are many other things that's related to this, in order to present the infrastructure. Do you think that June 12th will be a drop dead date or looking forward to seeing any -- because we have basically left six weeks.

Yes, June 12, 2009 will be the drop dead date.

ISSUE DATE: May 4, 2009

BY: Sharon M. Wiggins
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